

c. EMPLOYER'S NAME OR SCHOOL NAME		e. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		e. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize medical benefits to the undersigned physician or supplier for the procedure, service or supply listed below. SIGNED _____		11. AUTHORIZED PERSON'S SIGNATURE I authorize medical benefits to the undersigned physician or supplier for the procedure, service or supply listed below. SIGNED _____			
14. DATE OF CURRENT ILLNESS (First symptoms) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. _____ 17b. _____		10d. If applicable, enter the amount of recipient's Share of Cost (SOC) for the procedure, service or supply in Box 10d .	
19. RESERVED FOR LOCAL USE					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 3. _____					
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER					
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS H. EFFECT I. ID. QUAL. J. RENDERING PROVIDER ID. #	
1				NPI	
2				NPI	

Note: Do not enter a decimal point (.) or dollar sign (\$). Enter full dollar amount and cents even if the amount is even (for example, if billing for \$100, enter 10000 not 100).

If applicable, enter the amount of recipient's Share of Cost (SOC) for the procedure, service or supply in **Box 10d**.

Note: Do not enter a decimal point (.) or dollar sign (\$). Enter full dollar amount and cents even if the amount is even (for example, if billing for \$100, enter 10000 not 100).

If submitting a Medicare/Medi-Cal crossover claim, enter the Medicare Carrier Code in **Box 11c**.

c. EMPLOYER'S NAME OR SCHOOL NAME		e. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME		PATIENT
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>		
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE SIGNED: _____ to process this claim. I also request payment for services rendered below.				13. INSURED OR AUTHORIZED PERSON'S SIGNATURE I authorize medical benefits to the undersigned physician or supplier for services rendered below.		
<p>READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.</p> <p>Select Yes or No to indicate if the recipient has Other Health Coverage (OHC) in Box 11d.</p>						
14. DATE OF CURRENT ILLNESS OR INJURY (MM/DD/YY)		17a. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM/DD/YY)		PAYER INFORMATION
17b. NPI		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO		22. MEDICAID RESUBMISSION CODE		
19. RESERVED FOR LOCAL USE		23. PRIOR AUTHORIZATION NUMBER		24. DATE(S) OF SERVICE (MM/DD/YY)		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)		25. PROCEDURES, SERVICES, OR SUPPLIES (CPT/HCPCS)		26. CHARGES		
1. _____		2. _____		3. _____		
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643. _____		644. _____		645. _____		
646. _____		647. _____		648. _____		
649. _____		650. _____				

c. EMPLOYER'S NAME OR SCHOOL NAME		e. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME		PATIENT
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>		
<p>READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.</p> <p>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.</p> <p>SIGNED _____ DATE _____</p>						
<p>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</p> <p>SIGNED _____</p>						
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident or PREGNANCY)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		PAYER INFORMATION
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		19. RESERVED FOR LOCAL USE		21. DIAGNOSIS		
18. RESERVED FOR LOCAL USE		20. RESERVED FOR LOCAL USE		22. INITIAL REF. NO.		
23. RESERVED FOR LOCAL USE		24. A. DATE(S) OF SERVICE		25. B. PLACE OF SERVICE		
26. C. PROCEDURE, SERVICE, OR SUPPLIES (Explain Unusual Circumstances)		27. D. DIAGNOSIS		28. E. CHARGES		PAYER INFORMATION
29. F. DAYS OF UNITS		30. H. ICD-9-CM		31. I. QUAL.		
32. J. RENDERING PROVIDER ID. #		33. K. NPI		34. L. NPI		
35. M. NPI		36. N. NPI		37. O. NPI		
<p>If the OHC has paid, enter the amount in the upper right side of Box 11d. Do not enter a decimal point (.) or dollar sign (\$). Then complete fields 29 and 30.</p>						

If the OHC has paid, enter the amount in the upper right side of **Box 11d**. Do not enter a decimal point (.) or dollar sign (\$). Then complete fields **29** and **30**.

Not required by Medi-Cal. However, providers may note the Eligibility Verification Confirmation (EVC) number in **Box 13** for their own records.

Enter the date of onset of the recipient's illness, the date of accident/injury or the date of the last menstrual period (LMP) in **Box 14**.

c. EMPLOYER'S NAME OR SCHOOL NAME		e. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME		PATIENT ↓					
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____							
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. _____ 17b. NPI		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		↑ PAYER INFORMATION					
19. RESERVED FOR LOCAL USE				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY							
21. DIAGNOSIS 1. _____				20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES							
2. _____				22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.							
23. PRIOR AUTHORIZATION NUMBER											
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. ICD-9-CM (Per)	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1											NPI
2											NPI

Enter the name of the referring provider in **Box 17**.

c. EMPLOYER'S NAME OR SCHOOL NAME		e. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		f. INSURANCE PLAN NAME OR PROGRAM NAME		PATIENT ↓ ↑
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE		g. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>		
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.						
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.						
SIGNED						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. [Shaded Area]		18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		
17b. NPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		
19. RESERVED FOR LOCAL USE						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to B)						
1. _____ 3. _____						
2. _____ 4. _____						
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		
E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		
H. ICD-9-CM		I. ID. QUAL.		J. RENDERING PROVIDER ID. #		
1						
2						
10e. RESERVED FOR LOCAL USE						

On or after November 26, 2007, leave Box 17a blank.

From April 23 to November 25, 2007, enter the license number or Medi-Cal provider number of the referring or prescribing provider in the second shaded area of **Box 17a**.

From April 23 to November 25, 2007, enter the license number or Medi-Cal provider number of the referring or prescribing provider in the second shaded area of **Box 17a**.

On or after November 26, 2007, leave Box 17a blank.

c. EMPLOYER'S NAME OR SCHOOL NAME		e. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		e. INSURANCE PLAN NAME OR PROGRAM NAME		PATIENT ↓ ↑
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>		
<p>READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.</p> <p>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.</p>						
<p>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</p> <p>SIGNED _____</p>						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Ronald Davis M.D.		17a. _____ 17b. NPI		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		PAYER INFORMANT ↓ ↑
19. RESERVED FOR LOCAL USE				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 1)				20. OUTSIDE LAB? \$ CHARGES		
2. _____						
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG		C. D. PROCEDURES, SE (Explain Unusual C CPT/HCPCS)		
1						
2						

On or after November 26, 2007, you must enter the referring or prescribing provider's NPI in **Box 17b**.

From May 23 to November 25, 2007, enter the referring or prescribing provider's NPI, if available, in **Box 17b**.

Reminder: The license number or Medi-Cal provider number must still be entered in **Box 17a** during this period.

From May 23 to November 25, 2007, enter the referring or prescribing provider's NPI, if available, in **Box 17b**.

On or after November 26, 2007, you must enter the referring or prescribing provider's NPI in **Box 17b**.

Reminder: The license number or Medi-Cal provider number must still be entered in **Box 17a** during this period.

c. EMPLOYER'S NAME OR SCHOOL NAME		e. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME		PATIENT
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>		
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____		
14. DATE OF CURRENT: MM DD YY 06 04 07		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		↑
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Ronald Davis M.D.		17a. XXX456321 17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		
19. RESERVED FOR LOCAL USE				\$ CHARGES		
21. DIAGNOSIS OR NATURE OF ILLNESS 1. _____ 2. _____						↓ PAYER INFORMATION
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. ICD-9-CM (Rev. 09) I. ID. QUAL. J. RENDERING PROVIDER ID. #						
1 2						

Enter the dates of hospital admission and discharge if the services are related to hospitalization in **Box 18**. If the patient has not been discharged, leave the discharged date blank.

Enter the dates of hospital admission and discharge if the services are related to hospitalization in **Box 18**. If the patient has not been discharged, leave the discharged date blank.

c. EMPLOYER'S NAME OR SCHOOL NAME		e. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME		PATIENT
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>		
<p>READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.</p> <p>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary</p> <p>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</p>						
<p>14. DATE OF SERVICE (MM/DD/YY)</p> <p>17. NPI 4589871231</p> <p>19. RESERVED FOR LOCAL USE</p> <p>20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>21. DIAGNOSIS (ICD-9-CM)</p> <p>1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 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1014. 1015. 1016. 1017. 1018. 1019. 1020. 1021. 1022. 1023. 1024. 1025. 1026. 1027. 1028. 1029. 1030. 1031. 1032. 1033. 1034. 1035. 1036. 1037. 1038. 1039. 1040. 1041. 1042. 1043. 1044. 1045. 1046. 1047. 1048. 1049. 1050. 1051. 1052. 1053. 1054. 1055. 1056. 1057. 1058. 1059. 1060. 1061. 1062. 1063. 1064. 1065. 1066. 1067. 1068. 1069. 1070. 1071. 1072. 1073. 1074. 1075. 1076. 1077. 1078. 1079. 1080. 1081. 1082. 1083. 1084. 1085. 1086. 1087. 1088. 1089. 1090. 1091. 1092. 1093. 1094. 1095. 1096. 1097. 1098. 1099. 1100. 1101. 1102. 1103. 1104. 1105. 1106. 1107. 1108. 1109. 1110. 1111. 1112. 1113. 1114. 1115. 1116. 1117. 1118. 1119. 1120. 1121. 1122. 1123. 1124. 1125. 1126. 1127. 1128. 1129. 1130. 1131. 1132. 1133. 1134. 1135. 1136. 1137. 1138. 1139. 1140. 1141. 1142. 1143. 1144. 1145. 1146. 1147. 1148. 1149. 1150. 1151. 1152. 1153. 1154. 1155. 1156. 1157. 1158. 1159. 1160. 1161. 1162. 1163. 1164. 1165. 1166. 1167. 1168. 1169. 1170. 1171. 1172. 1173. 1174. 1175. 1176. 1177. 1178. 1179. 1180. 1181. 1182. 1183. 1184. 1185. 1186. 1187. 1188. 1189. 1190. 1191. 1192. 1193. 1194. 1195. 1196. 1197. 1198. 1199. 1200. 1201. 1202. 1203. 1204. 1205. 1206. 1207. 1208. 1209. 1210. 1211. 1212. 1213. 1214. 1215. 1216. 1217. 1218. 1219. 1220. 1221. 1222. 1223. 1224. 1225. 1226. 1227. 1228. 1229. 1230. 1231. 1232. 1233. 1234. 1235. 1236. 1237. 1238. 1239. 1240. 1241. 1242. 1243. 1244. 1245. 1246. 1247. 1248. 1249. 1250. 1251. 1252. 1253. 1254. 1255. 1256. 1257. 1258. 1259. 1260. 1261. 1262. 1263. 1264. 1265. 1266. 1267. 1268. 1269. 1270. 1271. 1272. 1273. 1274. 1275. 1276. 1277. 1278. 1279. 1280. 1281. 1282. 1283. 1284. 1285. 1286. 1287. 1288. 1289. 1290. 1291. 1292. 1293. 1294. 1295. 1296. 1297. 1298. 1299. 1300. 1301. 1302. 1303. 1304. 1305. 1306. 1307. 1308. 1309. 1310. 1311. 1312. 1313. 1314. 1315. 1316. 1317. 1318. 1319. 1320. 1321. 1322. 1323. 1324. 1325. 1326. 1327. 1328. 1329. 1330. 1331. 1332. 1333. 1334. 1335. 1336. 1337. 1338. 1339. 1340. 1341. 1342. 1343. 1344. 1345. 1346. 1347. 1348. 1349. 1350. 1351. 1352. 1353. 1354. 1355. 1356. 1357. 1358. 1359. 1360. 1361. 1362. 1363. 1364. 1365. 1366. 1367. 1368. 1369. 1370. 1371. 1372. 1373. 1374. 1375. 1376. 1377. 1378. 1379. 1380. 1381. 1382. 1383. 1384. 1385. 1386. 1387. 1388. 1389. 1390. 1391. 1392. 1393. 1394. 1395. 1396. 1397. 1398. 1399. 1400. 1401. 1402. 1403. 1404. 1405. 1406. 1407. 1408. 1409. 1410. 1411. 1412. 1413. 1414. 1415. 1416. 1417. 1418. 1419. 1420. 1421. 1422. 1423. 1424. 1425. 1426. 1427. 1428. 1429. 1430. 1431. 1432. 1433. 1434. 1435. 1436. 1437. 1438. 1439. 1440. 1441. 1442. 1443</p>						

c. EMPLOYER'S NAME OR SCHOOL NAME		e. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		f. INSURANCE PLAN NAME OR PROGRAM NAME		PATIENT
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE		g. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>		
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____		
14. DATE OF CURRENT: MM DD YY 06 04 07		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Ronald Davis M.D.		17a. NPI 4569871231		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 06 04 07 TO 06 07 07		PAYER INFORMATION
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 3. _____				23. PRIOR AUTHORIZATION NUMBER		
24. A. DA From MM DD		G. DAYS OR UNITS		H. ICD-9-CM Code	I. ID. QUAL.	
1				J. RENDERING PROVIDER ID. #		
2				NPI		
				NPI		

If you selected **Yes**, you must state in **Box 19** that a specimen was sent to an unaffiliated laboratory.

If you selected **Yes**, you must state in **Box 19** that a specimen was sent to an unaffiliated laboratory.

Enter all letters and/or numbers of the ICD-9-CM code for the **primary** diagnosis, including fourth and fifth digits if present in **Box 21.1**. Do **not** enter a decimal point.

c. EMPLOYER'S NAME OR SCHOOL NAME				e. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				e. INSURANCE PLAN NAME OR PROGRAM NAME			
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.			
<p align="center">READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.</p>											
12. PATIENT'S to process is below.				<p>If applicable, enter the Medicare status code in Box 22. Medicare status codes are required for Charpentier claims. In all other circumstances, these codes are optional.</p>							
SIGNED											
14. DATE OF C (MM DD YY)				17a. NAME OF REFERRING PROVIDER OR OTHER SOURCE				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY)			
16. DATE OF C (MM DD YY)				17b. NAME OF REFERRING PROVIDER OR OTHER SOURCE				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY)			
19. REFERRAL				20. REFERRAL				21. REFERRAL			
22. REFERRAL				23. REFERRAL				24. REFERRAL			
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34. REFERRAL				35. REFERRAL				36. REFERRAL			
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214. REFERRAL				215. REFERRAL				216. REFERRAL			
217. REFERRAL				218. REFERRAL				219. REFERRAL			

If applicable, enter the **secondary** ICD-9-CM code, including fourth and fifth digits if present, in **Box 21.2**. Do **not** enter decimal point.

If applicable, enter the Medicare status code in **Box 22**. Medicare status codes are required for Charpentier claims. In all other circumstances, these codes are optional.

For physician and podiatry services requiring a *Treatment Authorization Request* (TAR), enter the 11-digit TAR Control Number in **Box 23**.